FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

Rhode Island
Nursing Assistant Advisory Board

Room 105
3 Capitol Hill
Providence, RI 02908-5097

OFFICE USE ONLY

Instructions and Application For

License As A Nursing Assistant

By Reinstatement

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-5888 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 10/06/2005 awp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Licensure Requirements

All Reinstatement Applicants

- Recent passport type photograph.
- A Full Bureau of Criminal Investigation (BCI) Check from **each state** in which the applicant holds, **or has ever held, a nursing assistant license.**
- Photocopy of active license/registration from current state.
- Reinstatement Processing Fee: $24.00.
- Proof of employment for at least least one 8 hour shift within the past two years (license must be current at the time of employment) in Nursing Home, Hospital or Home Care Agency (See Employment Verification form, page 11).
- Verification from current state of licensure (see Interstate Verification form, page 10).

Rules and Regulations/Laws

The "Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Nursing Assistants and the Approval of Nursing Assistant Training Programs (R23-17.9-NA)" can be obtained at the following web site:

http://www.rules.state.ri.us/rules/released/pdf/DOH/DOH_3097.pdf

Chapter 23, Title 17.9 entitled "Registration of Nursing Assistants" can be downloaded at the following web site:

http://www.rilin.state.ri.us/statutes/title23/23-17.9/index.htm

Per "Rules and Regulations for the Registration of Nursing Assistants (R23-17.9)" as of April 1, 1992, all Nursing Assistants must complete an approved Training Program and a state administered Competency Evaluation test (or equivalent examination) in order to be registered as a Nursing Assistant. No person may be employed as a Nursing Assistant in Rhode Island unless registered and licensed as a Nursing Assistant in Rhode Island. When eligible for licensure, a Nursing Assistant license card with an identifying number will be mailed to you. Your registration is valid for up to two years.

Renewals

A renewal notice will be mailed to you approximately sixty (60) days prior to the license expiration date. You must obtain the signature of an official in a **licensed health care facility** (i.e. nursing home) where you were employed as a Nursing Assistant within the 24 months prior to renewal. **If you document that you were working in a facility other than a licensed health care facility, you will not be eligible for renewal.** **YOUR REGISTRATION MUST BE ACTIVE DURING ANY EMPLOYMENT PERIOD VERIFIED BY YOUR EMPLOYER.**

In-Service

Your employer must provide you with 12 hours of in-service per year, which you will be required to attend.

GENERAL INFORMATION (CONTINUED)

Complaints and Disciplinary Procedures

Complaints related to unprofessional conduct are received by the Department of Health from other state agencies. If the complaint involves a Nursing Assistant, the matter is referred to the Nursing Assistant Advisory Board. This Board recommends disciplinary action, after careful review of the evidence, to the Director. The Department of Health may suspend or revoke any registration or may reprimand, censure or otherwise discipline any individual who has been found guilty of violations of the Regulations (R23-17.9-NA). All hearings and reviews as may be required are conducted in accordance with the provisions of R42-35PP, which govern administrative procedures. Actions resulting in suspension or revocation for acts of abuse, neglect or misappropriation of patient/resident property are additionally reported in the federal registry.

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Nursing Assistant Advisory Board (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be submitted for an application to be considered complete. Applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year, a new application must be submitted.

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have a malpractice, criminal or disciplinary history in Rhode Island, or another state, it can take an additional 2 or 3 months for processing your application.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The BOARD may be emailed an address change. The email address is located at the following web site:

http://www.health.ri.gov/hsr/professions/n_assist.php

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

http://www.health.ri.gov/hsr/professions/license.php

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5888.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (5-8 and 12). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages MUST clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the reinstatement fee of **$24.00** payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
3. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 9). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

Rhode Island Department of Health
Nursing Assistant Advisory Board
Room 105, 3 Capitol Hill
Providence, RI 02908-5097

State of Rhode Island
Nursing Assistant Advisory Board

Application for License as a Nursing Assistant by Reinstatement

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in this or another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day Year 19

City and State; **OR** Province and Country, etc., if NOT U.S.

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code. If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Training Information

Please list the name and information about the training that you participated in that qualifies you for this license.

Name of School/Training Program

Address (Number and Street)

City | State | Zip Code –

License Number of School/Training Program:

Date Class Began: Month | Day | Year

Date Graduated: Month | Day | Year

Test Site:

Employment Date: (If Applicable) Month | Day | Year

Test Date: Month | Day | Year

9. Original (and Other) State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, list the license number(s) of the original state (and any other states) of licensure below:

Original Licensure

State | License Number

Other State Licensure

State | License Number

Other State Licensure

State | License Number

Other State Licensure

State | License Number

10. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

Month | Year

11. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper. If you answer "Yes" to any question you **must** attach originals, or certified copies of any court documentation to this application.

12. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Nursing Assistant in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Nursing Assistant Advisory Board of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant | Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ _____

Name of Notary (Print, Type or Stamp) | Signature of Notary

Notary Seal

_____ _____

Notary No/Commission No. | Commission Expiration Date (MM/DD/YY)

13. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the application as instructed (pages 5-8 and 12).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 12, **"Affidavit of Applicant"**, and have had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 13, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the ***"RI General Treasurer"*** in the amount of **$24.00** and attached it to the upper left-hand corner of the first (Top) page of the application (All fees are NON-REFUNDABLE).
- ☐ I have arranged my Board Application materials in the following order.

    1. Fee (attached as instructed).
    2. Board Application (including cover page) (pages 5-8 and 12).
    3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]

- ☐ I have mailed the above application materials directly to the Rhode Island Nursing Assistant Advisory Board.
- ☐ **I have mailed the "Interstate Verification form(s)" to all states where I have been licensed.**
- ☐ I have mailed "Verification of Employment" form to verify my full-time employment of at least one 8 -hour shift within the past two years in a nursing home, hospital, or home care agency.
- ☐ I have enclosed a photocopy of a current NA license from the state of _____.
- ☐ I have requested a full Bureau of Criminal Investigation (BCI) check as instructed.
- ☐ I have included the Manditory Addendum to License Application (Verification of Social Security Number)

Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license. Copy this form as needed.

Rhode Island Nursing Assistant Advisory Board

Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5888

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for reinstatement to practice as a Nursing Assistant in the State of Rhode Island. The Rhode Island Nursing Assistant Advisory Board requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Nursing Assistant Advisory Board at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number 19 Date of Birth

License Number _____ Date Issued _____

APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO THE OTHER STATE BOARD

THIS SECTION TO BE COMPLETED BY THE NURSING ASSISTANT BOARD

Directions for State Board: Please complete and return this form to the address above . *Please verify requirements met in your state:*
If you answer "yes" to any of the questions #5 through #8, please explain on a separate sheet of paper and attach it to this form.

Licensed by Examination? ☐ Yes ☐ No	If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Explain)		
Applicant has completed and passed the National Certification Exam: ☐ Yes ☐ No Score_____ Level of Exam:_____	License Status: ☐ Active ☐ Inactive ☐ Lapsed	Original Date Issued:	Expiration Date:

Questions:

1. Has this applicant met all relevant state and federal requirements under OBRA '87 and '89 for Nurse Aide Registration in the state of_____? ☐ Yes ☐ No

2. Please indicate method and state approved training program_____in the state of_____

   Date of Completion_____Number of hours_____

3. Competency Evaluation in state of_____ Date of Completion_____OR Reciprocity/Endorsement

   Registration in state of _____ Other method (please explain):_____

4. Registration Number_____Issued_____Expiration_____

5. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No

6. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No

7. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No

8. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "yes" to any of the questions #5 through #8, please explain on a separate sheet of paper and attach it to this form.

Certification:

Signature _____ Date _____

Type or Print Name

Title

Full Name of Licensing Board

Please Affix Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

For Reinstatement.
Substitute forms are not acceptable, copy this form as needed.

Rhode Island Nursing Assistant Advisory Board

Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5888

NURSING ASSISTANT VERIFICATION OF EMPLOYMENT FORM

I am applying for reinstatement of a license to practice as a Nursing Assistant in the State of Rhode Island. The Rhode Island Nursing Assistant Advisory Board requires that applicants for Rhode Island licensure who are reinstating their license must have this form verified and signed by the Employer/ Employing Agency. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Nursing Assistant Advisory Board at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number 19 Date of Birth

License Number _____ Date Issued _____

IMPORTANT!: APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO EMPLOYER

THIS SECTION TO BE COMPLETED BY THE EMPLOYER/EMPLOYING AGENCY

The individual named above has made application to the Rhode Island Department of Health, Nursing Assistant Advisory Board to become reinstated as a Nursing Assistant. Rhode Island Rules and Regulations for the licensure of Nursing Assistants requires any individual has worked in another state as a Nursing Assistant to obtain verification of Employment for a period of at least one 8-hour shift. This form is provided for that purpose.

This is to certify that _____ has completed a minimum of one 8-hour shift of employment in a skilled nursing facility.

Name of Skilled Nursing Facility: _____

Located at (street address): _____

City, State, Zip Code: _____

Dates of Employment: From_____ To_____
month/day/year month/day/year

Additional Comments:

_____

_____

_____

Certification:

_____ _____
Signature of Administrator/DNS Date

_____
Type or Print Name

_____
Title

Acknowledgement:

By signing this form,I hereby affirm that my comments and answers to the above questions are true and complete to the best of my knowlege

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. . These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case #)

☐ I am in state receivership. (Case #)

☐ I have been discharged from bankruptcy. (Case #)

Nursing Assistant by Reinstatement

Type of Professional License for which you are applying.

Full Name (Please Print or Type)

Social Security Number

Signature

Phone Number (including area code if not 401)

Date

This form must be completed, signed and attached to your license application for processing.